Bureau of Community Health Systems
Office of Primary Care and Rural Health
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Susan Mosier, MD, Acting Secretary | Department of Health & Environment | Sam Brownback, Governor

TO: Indigent Health Care Clinics and Other Organizations Designated as a Point of Entry

FROM: Office of Primary Care and Rural Health

SUBJECT: Annual Charitable Health Care Provider and Patient Information

In 1991, Kansas enacted legislation allowing indigent health care clinics and charitable health care providers to receive coverage under the Kansas Tort Claims Act for liability purposes. As an indigent health care clinic or other organization designated as a point of entry, we are asking for your assistance in the Office's efforts to update KDHE's information.

Step 1: Complete the attached short survey.

Step 2: Provide a list of the health care professions providing care through your clinic or organization. In addition to the provider's full name, indicate whether the provider is employed with, contracted with, or is a volunteer with your clinic/organization. A sample form is attached that may be used in gathering this information if needed.

Step 3: Return the completed survey and list of providers to KDHE Office of Primary Care and Rural Health. The survey and list may be sent our Office via e-mail, U.S. Mail or Fax.

E-Mail:
Address: primarycare@kdheks.gov
Subject Line: Charitable Health Care Provider Program Annual Report

U.S. Mail:
Attn: Charitable Health Care Provider Program Annual Report
Office of Primary Care and Rural Health
Bureau of Community Health Systems
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

Fax:
Number: 785-296-1231
Attn: Charitable Health Care Provider Program Annual Report

CHARITABLE HEALTH CARE PROVIDER ANNUAL REPORT

Organizational Name: _____

Please list two point of contacts for your organization.

Primary Contact Name and Title: _____

Phone: _____ Email: _____

Secondary Contact Name and Title: _____

Phone: _____ Email: _____

Please list the location(s) of your clinic including satellite clinics (if applicable).

If needed please add additional rows or attach list of all locations with this survey.

Address _____

City: _____ State: _____ Zip Code: _____ County: _____

Address _____

City: _____ State: _____ Zip Code: _____ County: _____

Address _____

City: _____ State: _____ Zip Code: _____ County: _____

Address _____

City: _____ State: _____ Zip Code: _____ County: _____

For the services listed below, please indicate services that are provided by your clinic, services for which your clinic provides referrals to another organization, and services your clinic does not provide.

	Provided directly by clinic	*Referred to another organization*	*Not provided/ not referred*
Prenatal Care	☐	☐	☐
Delivery/Postnatal Care	☐	☐	☐
Newborn screening & wellness checks	☐	☐	☐
Well Woman Checks	☐	☐	☐
Other screenings and preventive care	☐	☐	☐
Dental screenings and preventive care	☐	☐	☐
Dental Treatment	☐	☐	☐
Prescription Assistance	☐	☐	☐
Immunizations	☐	☐	☐
Smoking Cessation	☐	☐	☐
Substance Abuse Treatment	☐	☐	☐
Mental/Behavioral Health Services	☐	☐	☐
Chronic disease self-management	☐	☐	☐
Chronic care coordination	☐	☐	☐

Indigent Health Care Clinics and Point of Entries are expected to provide aggregated patient data annually.

Please select the appropriate statement and if applicable, completed the data tables below.

☐My clinic/organization's information for the previous calendar year has been entered into the Quality Reporting System, managed by the Kansas Association for Medical Underserved.

☐My clinic/organization's information for the previous calendar year is provided below. *(Complete data tables below)*

Calendar year: _____	**Number of Patients***	**Percent of Total Patients**
Uninsured		
Medicaid		
Medicare		
Third Party		
Other Public		
Unknown		

Federal Poverty Level	**Number of Patients***	**Percent of Total Patients**
0-100% poverty		
0-200% poverty		
> 200%		
Unknown		

**Patients are individuals who have at least one reportable visit during the reporting year. The term "patient" is not limited to recipients of medical or dental services; the term is used universally to describe all persons who receive countable visits. Patients should not include individuals who have limited contacts with the clinic whether or not documented on an individual basis.*

Please indicate number of healthcare providers (unduplicated) that work for or volunteer in your clinic/ organization?

Profession	***Employed or Contracted Staff***	***Volunteer Staff***
Physicians (MD or DO)		
Physician Assistants		
Advance Practice Nurses		
Registered or Licensed Practical Nurses (RN or LPN)		
Dentists (DDS or DO)		
Dental Hygienists		
Pharmacists		
Licensed Behavioral Health Providers		
Optometrists		
Occupational Therapists or Therapist Assistants		
Physical Therapists or Therapist Assistants		
Respiratory Therapist		
Podiatrist		
Chiropractor		
Other clinical (please list)		

Sample Form to Compile List of Health Care Professionals Providing Care Through Your Clinic/Organization

	Profession	*Employed*	*Contracted*	*Volunteer*
Example: Sara Roberts				*X*